ART® Use and Consent Form

I have been informed about the nature of Accelerated Resolution Therapy (ART®) treatment and wish to use it to work on the problem that brought me to therapy. I understand that my memories may be altered by the use of this therapy and I accept this as an outcome of the intervention.

I understand that distressing, unresolved memories may surface through use of the ART procedure. Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations. Distressing memories may seem to disappear, while more pleasant memories may take their place during ART. These negative memories may be more normally processed and then stored in a way which no longer distresses me. I have been advised to check with an attorney if I need to recall events for a legal procedure. I understand that subsequent to a treatment session the processing of incidents/material may continue, and other dreams, memories, flashbacks, feelings, etc. may surface.

I have been advised to check with my medical physician before beginning ART treatment concerning any medical conditions which might put me at risk, such as the possibility of heightened emotional reaction from an ART treatment, or any physical condition such as eye disease or traumatic brain injury which might be affected by the treatment.

Before commencing ART treatment I have thoroughly considered all the above. I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to have ART treatment, and by my signature below I hereby consent to receive ART treatment. My signature on this form is free from pressure or influence from any person or entity.

Name: _____ Date: _____

Signed: _____

Additional (circle one): Parent Guardian Witness

Name: _____ Date: _____

Signed: _____